

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011799	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/29/2011
NAME OF PROVIDER OR SUPPLIER GREEN TREE AT POST ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00096428.</p> <p>Complaint IN00096428 unsubstantiated due to lack of evidence.</p> <p>Survey date: November 29 2011</p> <p>Facility number: 011799 Provider number: 011799 AIM number: NA</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: Residential: 77 Total: 77</p> <p>Census payor type: Other: 77 Total: 77</p> <p>Sample: NA</p> <p>Green Tree at Post Road was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00096428.</p> <p>Quality review completed 11/29/11 Cathy Emswiller RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

L8NT11

If continuation sheet 1 of 1